



Anthem HealthKeepers
Offered by HealthKeepers, Inc.

Your Anthem HealthKeepers

Caroline County Public Schools
Anthem HealthKeepers
HealthKeepers 10 and 15
Point of Service Open Access Plans
Effective October 1, 2012

**Choosing the
right plan is a very
personal thing.**

Use this book to find one that's

- Right for your lifestyle
- Right for your needs
- Right for your peace of mind





**Please share your
feedback with us
in this short survey.**

Welcome to Anthem HealthKeepers benefits

We're glad you're taking time to check out all that Anthem HealthKeepers has to offer you. Choosing your benefits is an important decision and this booklet is designed to help. Basically, it's a snapshot of the benefits that come with Anthem HealthKeepers coverage. It shows what's available to you, what you get with each benefit and how the plans work.

Explore the Anthem HealthKeepers membership advantage.

We know you're busy. That's why we've made sure it only takes a few moments to explore the advantages of being an Anthem HealthKeepers member, including:

- There's a good chance your doctor is part of Anthem HealthKeepers' network. To find out, go to anthem.com and search the provider directory.
- You get more than access to coverage. You also get tools, resources and guidance that may help you reach your personal, healthy best.
- Anthem.com has the answers you need. Simply go to anthem.com for answers to your claims questions and find detailed health benefit information.
- This booklet goes into all this — and more. Please take a few minutes to look over the information, and keep this booklet. It may come in handy.

Registering on anthem.com is step one.

Once you get your ID card, registering is easy; all you need is your ID card, the Internet and five minutes. After you register at anthem.com, you can tap into decision-making tools, health information and many resources. It's also the convenient way to order a new ID card, check claims status, find out the cost of services, learn about doctors and hospitals, and so much more.

- Go to anthem.com
- Enter the site by clicking on Member
- Follow instructions to create your user name and password and you're ready to go!

Read on for information to help you choose your benefits with confidence. If you have any questions, your benefits manager will be happy to answer them. Thanks for considering Anthem HealthKeepers.

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Your Health Benefits

Anthem HealthKeepers POS Open Access Plan

The big buzz these days is that you have the power to take charge of your health. We would agree that's a good idea. That's why we build our health plans with options, resources and overall support to help you make decisions. This is a quick overview of how your plan works.

A primary doctor gives you the guided coverage of an HMO. Yet you can still go out-of-plan. That's flexible.

One, you have options. Anthem HealthKeepers POS is a Point-of-Service plan, which means you're free to choose doctors in or out-of-plan. This plan also includes an Open Access feature which allows you to seek specialist services without referrals. Of course, in-plan care will usually cost less than out-of-plan care. The Anthem HealthKeepers network includes many doctors and hospitals across Virginia, so you'll find plenty of choices. The point is, the choice is yours.

Two, as an Anthem HealthKeepers member, you have access to a lot of online tools. Helping you make your decisions is important to us, but not nearly as important as helping you make the right decisions – for you, your health and your budget.

Anthem HealthKeepers POS Open Access at a glance

- **Primary Care Physicians (PCPs):** Flexible
Your PCP provides preventive care and can be an advocate for helping you decide what types of specialist services may be of value to you. You can change your PCP as often as monthly, allowing you to “try on” different provider offices.
- **Referrals:** Not needed.
- **Claim Forms:** No claim forms to submit when using network providers.
- **Out-of-Plan Benefits:** Available for most services, but at more cost than when using in-plan providers. We've negotiated special rates with our network doctors and hospitals on behalf of our members. By staying in-network, you can take advantage of these rates and receive higher levels of coverage.
- **Out-of-Pocket:** This is the amount you'll pay, whether it is a straight copayment or some percentage of coinsurance for the cost of covered services.

You can see what services cost before your visit

Through anthem.com, you can estimate the costs for inpatient and outpatient services and doctor visits. What better way to help you determine what to do?

Anthem HealthKeepers POS Open Access Plan (continued)

You're covered whenever you travel

If you're traveling in the U.S. or out of the country, your coverage travels with you. If you need emergency, urgent or approved follow-up care, you have three options. Go to anthem.com, call BlueCard® Access at 800-810-2583 or call the customer service number on your member ID card.

You're getting more than a health plan

You get programs to actually help you manage your health. Wellness tools, 360° Health® health management programs and SpecialOffers@Anthem are all available through anthem.com. The programs are explained in detail later in this booklet. This is a brief overview of your plan's features. Your benefits summary contains the details. Thank you for considering Anthem HealthKeepers.

How to find a network doctor

Simply go online and search our provider directory for the type of care you need.

1. Go to anthem.com.
2. Select "Find a Doctor."
3. Enter your city and state or zip and click on "Search."
4. To see only a list of network providers, scroll down to "Insurance Options" and select "Add/Edit Selections."
5. Enter your state, select the HMO plan, then select "Anthem HealthKeepers" and click on "Search."

Anthem HealthKeepers 10 Point of Service Open Access Caroline County Public Schools

Covered Services	You Pay
Preventive Care Services	
Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits. *During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and your provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by your provider, which will result in a member cost share.	*No Charge
Doctor Visits	
<ul style="list-style-type: none"> office visits home visits urgent care visits in-office surgery voluntary family planning 	\$10 for each visit to your PCP \$20 for each visit to a specialist
Labs, Diagnostic X-rays and Other Outpatient Diagnostic Tests	
<ul style="list-style-type: none"> diagnostic x-rays diagnostic tests lab work <i>A copay does not apply when these services are provided by the same provider on the same day as the office visit.</i>	\$10 for each visit to your PCP \$20 for each visit to a specialist
<ul style="list-style-type: none"> advanced diagnostic imaging services 	\$150 for each visit
Autism Spectrum Disorder (ASD) – For children from age 2 through 6	
<ul style="list-style-type: none"> diagnosis and treatment of autism spectrum disorder including: <ul style="list-style-type: none"> behavioral health treatment* psychiatric care therapeutic care** pharmacy care psychological care <p>* Mental Health Services **Unlimited physical, occupational and speech therapy.</p>	Member cost shares will be dependent on the services rendered.
<ul style="list-style-type: none"> applied behavioral analysis <ul style="list-style-type: none"> limited to a \$35,000 per member annual maximum 	20% of the amount the health care professionals in our network have agreed to accept for their services
Early Intervention – For children from birth through age 2	
<ul style="list-style-type: none"> limited to a \$5,000 per member annual maximum* <p>*Unlimited physical, occupational and speech therapy</p>	Member cost shares will be dependent on the services rendered.
Other Outpatient Services	
<ul style="list-style-type: none"> hospice care 	No Charge
<ul style="list-style-type: none"> diabetic supplies, equipment and education 	Member cost shares will be dependent on the services rendered.
<ul style="list-style-type: none"> ambulance travel 	\$100 per transport
<ul style="list-style-type: none"> home health care (100 visits) 	\$20 per calendar month
<ul style="list-style-type: none"> durable medical equipment 	No Charge
<ul style="list-style-type: none"> prosthetic devices injectable medication*(excluding immunizations, preventive care, allergy injections and serum dispensed in a physician's office) <p>*You will also pay an additional \$10 or \$20 office visit copayment depending on the type of provider who treats you.</p>	20% of the amount the health care professionals in our network have agreed to accept for their services

For the benefits listed with specific limits, all services received during the calendar year from January 1 to December 31 for that benefit are applied to that limit (whether received in or out-of-plan).

Covered Services	You Pay
Therapy Services	
<ul style="list-style-type: none"> chemotherapy, radiation, cardiac and respiratory therapy physical and occupational therapy (30 combined visits)* speech therapy (30 visit limit)* spinal manipulation and manual medical therapy services (30 visit limit) 	\$20 for each visit
<i>* Limit does not apply to Early Intervention and Autism Spectrum Disorder.</i>	
<ul style="list-style-type: none"> dialysis 	\$20 per calendar month
Outpatient Infusion Services	
<ul style="list-style-type: none"> facility ambulatory infusion centers 	\$20 for each visit
<ul style="list-style-type: none"> home services 	10% of the amount the health care professionals in our network have agreed to accept for their services
Outpatient Surgery in a Hospital or Facility	
<ul style="list-style-type: none"> surgery 	\$150 for each visit
Inpatient Stays in a Hospital or Facility	
<ul style="list-style-type: none"> semi-private room private room when approved when approved in advance intensive or coronary care unit <p><i>*You do not have to pay another inpatient copay if you are readmitted for the same or related condition within less than 72 hours from when you went home.</i></p>	\$250 per admission*
<ul style="list-style-type: none"> skilled nursing facility (100 days for each admission) 	10% of the amount the health care professionals in our network have agreed to accept for their services
Maternity	
<ul style="list-style-type: none"> all routine pre- and postnatal care (excluding inpatient stays) 	\$50 per pregnancy
<ul style="list-style-type: none"> diagnostic testing (such as ultrasounds, non-stress tests and other fetal monitor procedures) 	\$20 for each visit
Outpatient Mental Health and Substance Abuse	
<ul style="list-style-type: none"> partial day mental health and substance abuse services 	No charge
<ul style="list-style-type: none"> medication management individual therapy up to 30 minutes in length group therapy other mental health and substance abuse visits 	\$20 for each visit
Routine Vision	
<ul style="list-style-type: none"> an annual routine eye exam <p><i>Plus valuable discounts on eyewear</i></p>	\$15 for each visit
Emergency Care and Out of the Service Area Urgent Care	
<ul style="list-style-type: none"> urgent care visits 	\$20 for each visit
<ul style="list-style-type: none"> true emergency care visits in or out of the service area <p><i>*Waived if admitted directly to the hospital.</i></p>	\$150 for each visit to an emergency room*
Out-of-Plan Services	
Deductible for services received from out-of-plan health care professionals	
You will pay all of the costs associated with covered services until you pay \$300 in one calendar year.	
<ul style="list-style-type: none"> If two people are covered under your plan, each of you will pay the first \$300 of the cost of your care (\$600 total). If three or more people are covered under your plan, together you will pay the first \$600 of the cost of your care. <p>However, the most one family member will pay is \$300.</p>	
Once this amount has been reached, we will pay 70% of the amount doctors, hospitals and other health care professionals have agreed to accept for the same covered services.	
If you go to an eye care professional not in our network for your routine eye examination, we will pay \$30 (whether or not you have reached the \$300 calendar year out-of-plan deductible) and you will pay the rest of what the professional charges.	
In addition, you may seek spinal manipulation and manual medical therapy services (chiropractic care) from a provider not in our network without first meeting the out-of-plan deductible.	

Out-of-Pocket Maximums

What You Will Pay for Covered Services in One Calendar Year (January 1 - December 31)

When using in-plan professionals

If you are the only one covered by your plan, you will pay \$1,500 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum.

- If two people are covered under your plan, each of you will pay \$1,500 (\$3,000 total).
- If three or more people are covered under your plan, together you will pay \$3,000. However, no family member will pay more than \$1,500 toward the limit.

When using out-of-plan professionals

If you are the only one covered by your plan, you will pay \$3,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum.

- If two people are covered under your plan, each of you will pay \$3,000 (\$6,000 total).
- If three or more people are covered under your plan, together you will pay \$6,000. However, no family member will pay more than \$3,000 toward the limit.

The following do not count toward the calendar year out-of-pocket maximum. You will still need to pay:

- the costs associated with vision benefits
- the cost of prescription drugs
- the cost of dental benefits
- the cost of care received when the benefit limits have been reached

Some benefits may be subject to balance billing, if provided by a non-participating provider. For more information on balance billing, see the enrollment brochure.

This benefits overview insert is only one piece of your entire enrollment package.

See the enrollment brochure for a list of your plan's exclusions and limitations and applicable policy form numbers.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

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Covered Services	You Pay
Preventive Care Services Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits. *During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and your provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by your provider, which will result in a member cost share.	*No Charge
Doctor Visits <ul style="list-style-type: none"> office visits home visits urgent care visits in-office surgery voluntary family planning 	\$15 for each visit to your PCP \$35 for each visit to a specialist
Labs, Diagnostic X-rays and Other Outpatient Diagnostic Tests <ul style="list-style-type: none"> diagnostic x-rays diagnostic tests lab work A copay does not apply when these services are provided by the same provider on the same day as the office visit.	\$15 for each visit to your PCP \$35 for each visit to a specialist
<ul style="list-style-type: none"> advanced diagnostic imaging services 	\$150 for each visit
Autism Spectrum Disorder (ASD) – For children from age 2 through 6 <ul style="list-style-type: none"> diagnosis and treatment of autism spectrum disorder including: <ul style="list-style-type: none"> behavioral health treatment* psychiatric care therapeutic care** pharmacy care psychological care * Mental Health Services **Unlimited physical, occupational and speech therapy.	Member cost shares will be dependent on the services rendered.
<ul style="list-style-type: none"> applied behavioral analysis <ul style="list-style-type: none"> limited to a \$35,000 per member annual maximum 	20% of the amount the health care professionals in our network have agreed to accept for their services
Early Intervention – For children from birth through age 2 <ul style="list-style-type: none"> limited to a \$5,000 per member annual maximum* *Unlimited physical, occupational and speech therapy	Member cost shares will be dependent on the services rendered.
Other Outpatient Services <ul style="list-style-type: none"> hospice care 	No Charge
<ul style="list-style-type: none"> diabetic supplies, equipment and education 	Member cost shares will be dependent on the services rendered.
<ul style="list-style-type: none"> ambulance travel 	\$100 per transport
<ul style="list-style-type: none"> home health care (100 visits) 	\$35 per calendar month
<ul style="list-style-type: none"> durable medical equipment 	No Charge
<ul style="list-style-type: none"> prosthetic devices injectable medication* (excluding immunizations, preventive care, allergy injections and serum dispensed in a physician's office) *You will also pay an additional \$15 or \$35 office visit copayment depending on the type of provider who treats you.	20% of the amount the health care professionals in our network have agreed to accept for their services

For the benefits listed with specific limits, all services received during the calendar year from January 1 to December 31 for that benefit are applied to that limit (whether received in or out-of-plan).

Option 1 3/12
CUSTOM

HealthKeepers, Inc., is an independent licensee of the Blue Cross and Blue Shield Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Covered Services	You Pay
Therapy Services	
<ul style="list-style-type: none"> physical and occupational therapy (30 combined visits)* spinal manipulation and manual medical therapy services (30 visit limit) speech therapy (30 visit limit)* *Limit does not apply to Early Intervention and Autism Spectrum Disorder.	\$25 for each visit
<ul style="list-style-type: none"> chemotherapy, radiation, cardiac and respiratory therapy 	\$35 for each visit
<ul style="list-style-type: none"> dialysis 	\$35 per calendar month
Outpatient Infusion Services	
<ul style="list-style-type: none"> facility ambulatory infusion centers 	\$35 for each visit
<ul style="list-style-type: none"> home services 	20% of the amount the health care professionals in our network have agreed to accept for their services
Outpatient Surgery in a Hospital or Facility	
<ul style="list-style-type: none"> surgery 	\$150 for each visit
Inpatient Stays in a Hospital or Facility	
<ul style="list-style-type: none"> semi-private room private room when approved when approved in advance intensive or coronary care unit *You do not have to pay another inpatient copay if you are readmitted for the same or related condition within less than 72 hours from when you went home.	\$200 per day (not to exceed \$1000) for an admission*
<ul style="list-style-type: none"> skilled nursing facility (100 days for each admission) 	20% of the amount the health care professionals in our network have agreed to accept for their services
Maternity	
<ul style="list-style-type: none"> all routine pre- and postnatal care (excluding inpatient stays) 	\$100 per pregnancy
<ul style="list-style-type: none"> diagnostic testing (such as ultrasounds, non-stress tests and other fetal monitor procedures) 	\$35 for each visit
Outpatient Mental Health and Substance Abuse	
<ul style="list-style-type: none"> partial day mental health and substance abuse services 	No charge
<ul style="list-style-type: none"> medication management individual therapy up to 30 minutes in length group therapy 	\$20 for each visit
<ul style="list-style-type: none"> other mental health and substance abuse visits 	\$30 for each visit
Routine Vision	
<ul style="list-style-type: none"> an annual routine eye exam Plus valuable discounts on eyewear	\$15 for each visit
Emergency Care and Out of the Service Area Urgent Care	
<ul style="list-style-type: none"> urgent care visits 	\$35 for each visit
<ul style="list-style-type: none"> true emergency care visits in or out of the service area *Waived if admitted directly to the hospital.	\$150 for each visit to an emergency room*
Out-of-Plan Services	
Deductible for services received from out-of-plan health care professionals	
<p>You will pay all of the costs associated with covered services until you pay \$400 in one calendar year. If two or more people are covered under your health plan, each member will be responsible for paying the first \$400 toward covered services within a calendar year.</p>	
<ul style="list-style-type: none"> If two people are covered under your plan, each of you will pay the first \$400 of the cost of your care (\$800 total). If three or more people are covered under your plan, together you will pay the first \$800 of the cost of your care. <p>However, the most one family member will pay is \$400.</p>	
<p>Once this amount has been reached, we will pay 70% of the amount doctors, hospitals and other health care professionals have agreed to accept for the same covered services.</p>	
<p>If you go to an eye care professional not in our network for your routine eye examination, we will pay \$30 (whether or not you have reached the \$400 calendar year out-of-plan deductible) and you will pay the rest of what the professional charges.</p>	
<p>In addition, you may seek spinal manipulation and manual medical therapy services (chiropractic care) from a provider not in our network without first meeting the out-of-plan deductible.</p>	

Out-of-Pocket Maximums

What You Will Pay for Covered Services in One Calendar Year (January 1 - December 31)

When using in-plan professionals

If you are the only one covered by your plan, you will pay \$2,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum.

- If two people are covered under your plan, each of you will pay \$2,000 (\$4,000 total).
- If three or more people are covered under your plan, together you will pay \$4,000. However, no family member will pay more than \$2,000 toward the limit.

When using out-of-plan professionals

If you are the only one covered by your plan, you will pay \$3,500 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum.

- If two people are covered under your plan, each of you will pay \$3,500 (\$7,000 total).
- If three or more people are covered under your plan, together you will pay \$7,000. However, no family member will pay more than \$3,500 toward the limit.

The following do not count toward the calendar year out-of-pocket maximum. You will still need to pay:

- the costs associated with vision benefits
- the cost of prescription drugs
- the cost of dental benefits
- the cost of care received when the benefit limits have been reached

Some benefits may be subject to balance billing, if provided by a non-participating provider. For more information on balance billing, see the enrollment brochure.

This benefits overview insert is only one piece of your entire enrollment package.

See the enrollment brochure for a list of your plan's exclusions and limitations and applicable policy form numbers.

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Your prescription drug plan

Your Prescription Drug 10-20-35	Tier 1 Copay	Tier 2 Copay	Tier 3 Copay
Up to a 30-day medication supply at participating retail pharmacies	\$10	\$20	\$35
Up to a 90-day medication supply delivered to your home	\$10	\$40	\$105

There will also be a \$3,500 per member per benefit year out-of-pocket maximum included with this benefit.

Retail pharmacy network

Our network includes more than 56,000 pharmacies across the country. That means you have easy access to your prescriptions wherever you are – at work, home or even on vacation. Using pharmacies in the network will help you get the most from your drug plan. When picking up your prescription at the pharmacy, be sure to show your plan ID card.

To make sure your pharmacy's in our network, visit anthem.com.

- Log in and click on "Refill a Prescription." You will be directed to the Express Scripts website.
- Click on "My Prescription Plan" in the left hand column.
- Click on "Find a Pharmacy."

Choosing a non-network pharmacy means you'll pay the full cost of your drug. Then, you may submit a claim form to be repaid. To access the form, visit **anthem.com**.

- Log in and select the "Refill a Prescription" link. You will be directed to the Express Scripts website.
- Click on "My Prescription Plan" in the left-hand column, then click on "Coverage & Copayments." The claim form is on this page.

Note about your pharmacy information on the web:

Express Scripts is the company that manages the operations of your drug plan. The first time you're directed to the Express Scripts website, you'll go through a brief registration. The purpose is to set your preferences for communication and privacy. You'll do this only once.

To access your pharmacy information, log on to **anthem.com**.

Home Delivery Pharmacy

Home delivery is for people who take medications on an ongoing basis. Our preferred Home Delivery Pharmacy, managed by Express Scripts, sends you the medicine you need, right to your door. As a home delivery customer, you'll also enjoy:

- Free standard shipping
- Access to pharmacists for drug questions
- Safe, accurate prescriptions

Your prescription drug plan (continued)

Getting started with home delivery

Switching is simple. You can order by mail or fax. Your order should arrive within 14 days from the date your order is received.

By mail: Visit **anthem.com** to get an order form.

- Log in and select "Refill a Prescription." You will be directed to the Express Scripts website.
- Click on "Fill a New Prescription."
- Choose the "Print a Prescription Order Form" link. You can print the form and complete it by hand. Or you can fill out a web-based form and print it.
- Mail your completed form, prescription from your doctor for a 90 day supply, and payments to:

Home Delivery Pharmacy
PO Box 66785
St. Louis MO 63166-6785

By fax: Have your doctor fax your prescription and plan ID card information to **800-600-8105**. It must be faxed directly from your doctor's office. If there is a question about your prescription, the pharmacy will contact your doctor.

Ordering refills

With home delivery, you don't have to worry about running out of medication. That's because the pharmacy will let you know when it's time to order refills. You can easily order by phone, mail or online:

By phone: Have your prescription label and credit card ready. Call **866-281-4279** and select "Automated Refill Order Line" option from the menu. Or press zero at any time to speak with a patient care advocate. If you are speech or hearing impaired, call **800-899-2114**. Follow the prompts to place your order.

By mail: Fill out an order form you received with a previous order. Affix your label or write the prescription refill number in the space provided. Mail the order form with the proper payment to:

Home Delivery Pharmacy
PO Box 66785
St. Louis MO 63166-6785

Online: Visit **anthem.com**.

- Log in and select "Refill a Prescription". You will be directed to the Express Scripts website.
- Choose the drugs you want to refill, and click "Add Refills to Cart."
- Review the order, shipping method, payment, medical information and contact information, and make changes if needed.
- Click "Place My Order."

Specialty Pharmacy

CuraScript, the Express Scripts specialty pharmacy, provides support and medicine for people with complex, long-term conditions. They include (but are not limited to):

- Asthma
- Bleeding Disorders
- Cancer
- Cystic Fibrosis
- Crohn's Disease
- Growth Hormone

Your prescription drug plan (continued)

- Hepatitis
- HIV/AIDS
- Iron Overload
- Multiple sclerosis
- Psoriasis
- Pulmonary arterial hypertension
- Rheumatoid arthritis
- Respiratory syncytial virus (RSV)
- Transplant

Nurses, pharmacists and patient care advocates work together to help improve your care. Their goal is to help you get the best results from your treatments.

CuraScripts CareLogic® programs help people with the conditions listed on this page. These programs teach you about treatment for your condition and help you understand and cope with medication and side effects. CareLogic nurses and pharmacists will schedule time with you to find out how you are doing. They will also help you manage the side effects of treatment.

Call 888-773-7376 to learn about how CareLogic can help you better manage your health condition.

Ordering specialty drugs

You can place your first order by phone or fax:

By phone: Call **800-870-6419**, Monday through Friday, 8 a.m. to 9 p.m. and Saturday 9 a.m. to 1 p.m., Eastern time. A patient care advocate will help you get started.

By fax: Ask your doctor to fax your prescription and a copy of your ID card to **800-824-2642**.

Ordering refills

Online: Visit **anthem.com**.

- Log in and select "Refill a Prescription." You will be directed to the Express Scripts website.
- Chose the drugs you want to refill, and click "Add refills to Cart."
- Review the order, shipping method, payment, medical information and contact information and make changes if needed.
- Click "Place My Order."

Note: For some drugs, you must call to order a refill.

Drug list

Our drug list (sometimes called a formulary) is a list of prescription drugs covered by your plan. It's made up of hundreds of brand and generic drugs.

We research drugs and select ones that are safe, work well and offer the best value. That's because we think it's important to cover drugs that help people stay healthy so they can work, go to school, and continue the activities of a busy life.

Sometimes we update the Drug List if new drugs come to market, or if new research becomes available. To view the current list, visit **anthem.com**. Click on "Customer Care" in the top-right corner. Select your state, then click "Download Forms." You'll find the Drug List on this page.

If you don't have access to a computer, you can check the status of a drug by calling Customer Service at the phone number on your plan ID card.

Generic drugs

Your prescription drug plan (continued)

If you're taking a brand name drug, you could save money by switching to an effective, lower cost generic drug. Your plan covers both brand and generic (or non-brand) drugs. When you choose a generic, you'll get the effectiveness of a brand drug – but usually at a lower cost.

Brand and generic drugs have the same active ingredient, strength and dose. And generics must meet the same high standards for safety, quality and purity.

Prescription drugs will always be dispensed as ordered by your physician. If you or your doctor requests a brand name drug when a generic is available, you will pay your usual copayment for the generic drug plus the difference in the allowable charge between the generic and brand name drug.

Why generics cost less

Developing a new drug is expensive. When a company creates a new drug, it gets a patent for up to 20 years. That means only the company that created it can sell it during that time. Once the patent expires, other companies can make copies of the same drug. These companies avoid the high costs of developing the drug – and that helps lower the price for you.

Talk to your doctor to see if a generic is right for you. Don't switch or stop taking any drugs until you talk to your doctor.

Prior authorization

Most prescriptions are filled right away when you take them to the pharmacy. But, some drugs need our review and approval before they're covered. This process is called prior authorization. It focuses on drugs that may have:

- Risk of serious side effects
- High potential for incorrect use or abuse
- Better options that may cost you less
- Rules for use with very specific conditions

If your drug needs approval, your pharmacist will let you know. To check in advance, call the Customer Service phone number on your ID plan card.

The Drug List also includes this information. To view it, visit anthem.com. click on "Customer Care" in the top-right corner. Select your state, then click on "Download Forms." You'll find the Drug List on this page.

Anthem Blue Cross and its HMO affiliate, HealthKeepers, Inc., receives financial credits from drug manufacturers based on total volume of the claims processed for their product utilized by Anthem Blue Cross and Blue Shield and Anthem HealthKeepers members. These credits are retained by Anthem Blue Cross and Blue Shield and HealthKeepers, Inc. as a part of its fee for administering the program for self-funded groups and used to help stabilize rates for fully-insured groups. Reimbursements to pharmacies are not affected by these credits.

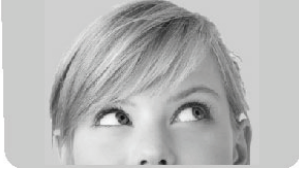
Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Anthem Blue Cross and Blue Shield and its affiliated HMO, HealthKeepers, Inc., are independent licensees of the Blue Cross and Blue Shield Association. ®ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

This benefits overview insert is only one piece of your entire enrollment package. See the enrollment brochure for a list of your plan's exclusions and limitations and applicable policy form numbers.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

WELCOME TO BLUE VIEW VISION!

Good news—your vision plan is flexible and easy to use. This benefit summary outlines the basic components of your plan, including quick answers about what's covered, your discounts, and much more!



Blue View VisionSM Exam Only A15 Plan



Anthem HealthKeepers

Your Blue View Vision network

Blue View Vision offers you one of the largest vision care networks in the industry, with a wide selection of experienced ophthalmologists, optometrists, and opticians. Blue View Vision's network also includes convenient retail locations, many with evening and weekend hours, including LensCrafters®, Sears OpticalSM, Target Optical®, JCPenney® Optical and most Pearle Vision® locations. Best of all – when you receive care from a Blue View Vision participating provider, you can maximize your benefits and money-saving discounts. Members may call Blue View Vision toll-free at the telephone number listed on the back of their ID card with questions about vision benefits or provider locations.

YOUR BLUE VIEW VISION PLAN AT-A-GLANCE

VISION CARE SERVICES

Routine eye exam (once every calendar year)

Retinal Imaging - *at member's option can be performed at time of eye exam*

IN-NETWORK

\$15 copay, then covered in full

Discounted member cost up to \$39

OUT-OF-NETWORK

\$30 allowance

Discount not available

USING YOUR BLUE VIEW VISION PLAN

The Blue View Vision network is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network.

ADDITIONAL SAVINGS ON EYEWEAR AND MORE

As a Blue View Vision member, you can take advantage of valuable discounts through our Additional Savings program. Just visit a participating Blue View Vision eye care professional or vision center and enjoy 35% off the retail price* of eye glass frames and 15% off the retail price of conventional (non-disposable) contact lenses. You can also save 20% off the retail price of non-prescription sunglasses and eye care accessories. Plus you'll get special member savings* on standard eyeglass lenses, lens treatment options and upgrades. Restrictions may apply and discounts are subject to change without notice.

*Discounts do not apply in the event the manufacturer has imposed a no discount policy on the frame. Discount on frames and special member pricing apply when complete pairs of eyeglasses are purchased together. If purchased separately, members receive a 20% discount off the retail price.

OUT-OF-NETWORK

Did we mention we're flexible? You can choose to receive care outside of the Blue View Vision network. You simply get an allowance toward your eye exam and you pay the rest. In-network benefits and discounts will not apply. When visiting an out-of-network provider, you are responsible for payment of services at the time of service. If you choose an out-of-network provider, please complete the out-of-network claim form and submit it along with your itemized receipt via any of the following methods:

Fax: 866-293-7373

Email: oonclaims@eyewearspecialoffers.com

Mail: Blue View Vision, Attn: OON Claims, P.O. Box 8504, Mason, OH 45040-7111

EXCLUSIONS & LIMITATIONS

This is a primary vision care benefit and is intended to cover only eye examinations. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force.

Combined Offers. Not combined with any offer, coupon, or in-store advertisement.

Experimental or Investigative. Any experimental or investigative services.

Uninsured. Services received before insured person's effective date or after coverage ends.

Excess Amounts. Any amounts in excess of covered vision expense.

Eyewear. Any type of eyewear and related materials including eyeglass lenses, frames, or contact lenses.

Routine Exams or Tests. Routine examinations required by an employer in connection with insured person's employment.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if insured person does not claim those benefits.

Government Treatment. Any services actually given to the insured person by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if insured person is not required to pay for them or they are given to the insured person for free.

Services of Relatives. Professional services or supplies received from a person who lives in insured person's home or who is related to insured person by blood or marriage.

Voluntary Payment. Services for which insured person is not legally obligated to pay. Services for which insured person is not charged. Services for which no charge is made in the absence of insurance coverage.

Not Specifically Listed. Services not specifically listed in this plan as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the insured person and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Eye Surgery. Any medical or surgical treatment of the eyes and any diagnostic testing. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Hospital Care. Inpatient or outpatient hospital vision care.

Orthoptics. Orthoptics or vision training and any associated supplemental testing.

Crime or Nuclear Energy. Conditions that result from: (1) insured person's commission of or attempt to commit a felony; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available.

This information is intended to be a brief outline of coverage. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's Policy, which shall control in the event of a conflict with this overview. This benefit overview insert is only one piece of your entire enrollment package.

Take care of yourself. Use your preventive care benefits.

Getting regular checkups and exams can help you stay well, catch problems early and may be lifesaving. Our health plans cover 100% of the services listed in this flier as preventive care.¹ This follows the health care reform law and state regulations. When you get these services from providers in the network, you don't have to worry about paying anything out of your own pocket for covered preventive care such as screenings, immunizations and exams. You may have to pay part of the costs if you use a provider outside the network.

Here's an overview of the types of preventive services we cover. Refer to your benefits summary to learn more.

Preventive versus diagnostic care

What's the difference? Preventive care is precautionary. Diagnostic care is used to find the cause of existing symptoms. For example, if your doctor suggests you have a colonoscopy because of your age, that's preventive care. But, if your doctor suggests a colonoscopy to see what's causing your symptoms, that's diagnostic care and you may need to pay part of the cost (this is your "cost share").

Child preventive care (birth to 18 years)

Preventive care physical exams are covered as well as the screenings, tests and vaccines listed here. The preventive care services listed below may not be right for every person. Please ask your health care provider what's right for you.

- Screening for depression
- Screening and counseling for obesity
- Behavioral counseling to promote a healthy diet
- Screening for sexually transmitted infections
- Pelvic exam and Pap test, including screening for cervical cancer

Preventive physical exams

Age-appropriate screening tests may include:

- Newborn screenings
- Vision screening²
- Hearing screening
- Developmental and behavioral assessments
- Oral health assessment
- Screening for lead exposure
- Hemoglobin or hematocrit (blood count)
- Blood pressure
- Height, weight and body mass index (BMI)
- Cholesterol and lipid level screening

Immunizations:

- Hepatitis A
- Hepatitis B
- Diphtheria, Tetanus, Pertussis
- Varicella (chicken pox)
- Influenza (flu)
- Pneumococcal (pneumonia)
- Human Papillomavirus (HPV)
- Haemophilus Influenza type b (Hib)
- Polio
- Measles, Mumps, Rubella (MMR)
- Meningococcal (meningitis)
- Rotavirus

Take care of yourself. Use your preventive care benefits. (continued)

Adult preventive care (19 years and older)

Preventive care physical exams are covered as well as the screenings, tests and vaccines listed here. The preventive care services listed below may not be right for every person. Please ask your health care provider what's right for you.

Preventive physical exams

Age-appropriate screening tests may include:

- Eye chart vision screening²
- Hearing screening
- Cholesterol and lipid level screening
- Blood pressure
- Height, weight and BMI
- Screening for depression
- Diabetes screening
- Prostate cancer screening including digital rectal exam and PSA test
- Breast cancer screening, including exam and mammography
- Pelvic exam and Pap test, including screening for cervical cancer
- Screening for sexually transmitted infections
- HIV screening
- Bone density test to screen for osteoporosis
- Colorectal cancer screening including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and CT colonography (as appropriate)

- Aortic aneurysm screening (men)
- Screenings during pregnancy (including but not limited to, hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, iron deficiency anemia, gonorrhea, chlamydia and HIV)
- Intervention services (includes counseling and education):
 - Screening and counseling for obesity
 - Genetic counseling for women with a family history of breast and/or ovarian cancer
 - Behavioral counseling to promote a healthy diet
 - Primary care intervention to promote breastfeeding
 - Counseling related to aspirin use for the prevention of cardiovascular disease (does not include coverage for aspirin)
 - Screening and behavioral counseling related to tobacco use
 - Screening and behavioral counseling related to alcohol misuse

Immunizations:

- Hepatitis A
- Hepatitis B
- Diphtheria, tetanus, pertussis
- Varicella (chicken pox)
- Influenza (flu)
- Pneumococcal (pneumonia)
- Human Papillomavirus (HPV)
- Measles, Mumps, Rubella (MMR)
- Meningococcal (meningitis)
- Zoster (shingles)

This sheet is not a contract or policy with Anthem Blue Cross and Blue Shield. If there is any difference between this sheet and the group policy, the provisions of the group policy will govern. Please see your combined Evidence of Coverage and Disclosure Form or Certificate for Exclusions & Limitations.

¹ Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits
² Some plans cover additional vision services. Please see your contract or Certificate of Coverage for details.

Coverage While Traveling

Whether you're traveling on business, away for fun or have been stationed in another state, your coverage travels with you. The BlueCard® program makes sure of that by uniting the Anthem HealthKeepers' network with those of other Blue Cross and Blue Shield companies across the U.S. You'll have access to medical care most anywhere you're staying.

It's as easy as accessing your local network.

Getting medical care away from home is as convenient as accessing the local network — with just one added step.

1. Find a provider from the BlueCard listing. Like when at home, you can search online at [anthem.com](https://www.anthem.com) or call the member services number on the back of your member ID card. You can also call BlueCard Access at 800-810-BLUE (2583).
2. (This is the additional step.) Call Anthem HealthKeepers member services to verify your coverage.
3. Show your ID card at the time of service.
4. As an Anthem HealthKeepers Point of Service (POS) member, you are covered for office visits and other services at the same cost as out-of-network visits when you are at home.

One additional step. No additional costs or hassles. You pay the same with any Blue Cross and Blue Shield provider as you would an Anthem HealthKeepers network provider. Plus the provider will file your claims for you. Anthem HealthKeepers will still mail your explanation of benefits so you can double-check how the service was covered.

As always, if you need emergency care, you should go to the nearest hospital without contacting Anthem first. Just give us a call within 24 hours or as soon as reasonably possible.

Enjoy your travels. We're happy to go with you.

How to understand your Explanation of Benefits (EOB)

We will send you an Explanation of Benefits EOB when a health care provider (doctor, specialist, hospital, lab facility or other health care professional) files a claim for your care. An EOB is not a bill, but it can help you figure out if you need to pay anything to your health care provider.

Here is a sample of an EOB with some of the key parts and what they mean:

1. **Mailing address.** Use this address to send claims and letters.
2. **Phone numbers to reach Customer Service representatives.** Please call this number if you have a question about your benefits or claim.
3. **Customer name and mailing address.** Your name and address
4. **The date this EOB was printed, your identification number, and your group name.** Use this information if you need to call about a claim.

A Customer Service Representative will be available to assist you with any questions concerning your Explanation of Benefits.
Richmond Area: (804) 358-1551 Toll Free: (800) 451-1527
Business Hours: Mon-Thurs 8:30AM-5:00PM Friday 8:30AM-4:00PM

2015 Staples Mill Road
Post Office Box 27401
Richmond, Virginia 23279

EXPLANATION OF BENEFITS
THIS IS NOT A BILL
Retain This For Your Records
Payment was sent to the provider.

Group Name: ANY GROUP VA This Explanation of Benefits Was Prepared On: 06/11/2003

Patient's Name: JOHN Q CUSTOMER Identification Number: XXX-XX-XXXX

TOTAL AMOUNT WE PAID: \$55.00	TOTAL IN NETWORK SAVINGS: \$0.00 <small>Amount saved by using network providers.</small>	WHAT YOU MAY OWE PROVIDER(S): \$10.00 <small>The provider(s) can bill you for this amount if you have not yet paid.</small>
Service Provider/ Claim Information	Provider Charges	Network Savings
ASSOCIATED PHYSICIANS Claim Number 2019242100000 Date(s) of Service 03/19/03 Medical Care	65.00	0.00
Allowable Charges	Amount Paid	What You May Owe
65.00	55.00	Deductible 10.00
TOTAL:	\$65.00	\$0.00
	\$65.00	You May Owe \$10.00

Remark(s) Explanation:
1 This claim has been approved and applied to your deductible.

5. **Total Amount We Paid:** What we paid to the provider(s) for the service(s) you got.
6. **Network Savings:** The amount that you save by seeing a network provider.
7. **What You May Owe Provider(s):** The amount you may owe the provider(s) for the service(s) you got.
8. **Servicing Provider and Claim Information:** The name of the provider who treated you. For example, the name of your doctor or the hospital where you got care.
Claim Number: The number given to the claim as it is received.
Date(s) of Service: The date or dates of service for the claim.
Type of Service: The type of care you got. This could be outpatient or inpatient services.
9. **Provider Charges:** How much the provider billed for your care.
10. **Network Savings:** How much you save by going to an in-network provider.
11. **Allowable Charges:** The most that a doctor, hospital or other health care provider will be paid for a service under your benefits. For more information, see your benefits information.
12. **Amount Paid:** How much Anthem is paying the provider.
13. **What You May Owe:** This is how much you owe to the provider, plus any deductible, coinsurance or copays that may apply to this claim. If it applies, this will include any charges for services you got that are not covered under your benefit plan.
14. **Remark(s) Explanation:** More information about the claim. The number goes with the number in the "REMARK" column on the EOB as it applies to a claim.

Ins and Outs of Coverage

Tips for understanding your coverage

(for Open Access, Point of Service or Value Advantage Plans)

Knowing the “rules of the road” for the plan you have selected can make all the difference in getting the most value from your Anthem HealthKeepers coverage. Here are a few tips to keep in mind when seeking services.

Services that require advance reviews

While you can see any doctor or go to any hospital you like, there may be instances in which a test or procedure your doctor wants you to have may not be covered. To help you minimize unanticipated costs from a non-covered service, we work with our in-network providers to make sure that certain services go through an advance review process first. This way, you'll know upfront whether the service is going to be covered.

An explanation on how we define emergencies

An emergency is the sudden onset of a medical condition with such severe symptoms that a person with an average knowledge of health and medicine would seek medical care immediately because there may be:

- serious risk to mental or physical health
- danger or significant impairment of body function
- significant harm to organs in the body (heart, brain, kidneys, liver, lungs, etc.)
- danger to the health of the baby in a pregnant woman

Balance Billing

In some situations, such as an emergency, getting the care you need is the first priority. During these times, if you receive care from hospitals and/or providers who have not contracted with us, they can charge whatever they want for their services. If what they charge is more than providers in our network have agreed to accept for the same service, you can be billed for the difference. This is called “balance billing.”

The ins and outs of coverage

Knowing that you have health care coverage that meets your and your family's needs is reassuring.

But part of your decision in choosing a plan also requires understanding:

- who can be enrolled
- how coverage changes are handled
- what's not covered by your plan
- how your plan works with other coverage

Who can be enrolled

You can choose coverage for you alone or family coverage that includes you and any of the following family members:

- Your spouse
- Your children age 26 or younger, which includes:
 - A newborn, natural child or a child placed with you for adoption
 - A stepchild, or
 - Any other child for whom you have legal guardianship

Coverage will end on the last day of the month in which they turn 26.

Some children have mental or physical challenges that prevent them from living independently. The dependent age limit does not apply to these enrolled children as long as these challenges were present before they reached age 26.

The ins and outs of coverage (continued)

1. On the employer level — which impacts you as well as all employees under your employer's plan — your Anthem HealthKeepers plan can be ...

renewed	cancelled	changed	when ...
•			your employer maintains its status as an employer, remains located in our service area, meets our guidelines for employee participation and premium contribution, pays the required health care premiums and does not commit fraud or misrepresent itself.
	•		your employer makes a bad payment, voluntarily cancels coverage (30-day advance written notice required), is unable (after being given at least a 30-day notice) to meet eligibility requirements to maintain a group plan, or still does not pay the required health care premium (after being given a 31-day grace period and at least a 15-day notice).
	•		we decide to no longer offer the specific plan chosen by your employer (you'll get a 90-day advance notice) or if we decide to no longer offer any coverage in Virginia (you'll get a 180-day advance notice).
		•	your employer and you received a 30-day advance written notice that the coverage was being changed (services added to your plan or the copayment amounts decreased). Copayments can be increased or services can be decreased only when it is time for your group to renew its Lumenos coverage.

2. On an individual level — factors that apply to you and covered family members — your Anthem HealthKeepers plan can be ...

renewed	cancelled	when ...
•		you maintain your eligibility for coverage with your employer, pay your required portion of the health care premium and do not commit fraud or misrepresent yourself.
	•	you purposely give wrong information about yourself or your dependents when you enroll. Cancellation is effective immediately.
	•	you lose your eligibility for coverage, don't make required payments or make bad payments, commit fraud, are guilty of gross misbehavior, don't cooperate with coordination of benefits recoveries, let others use your ID card, use another member's ID card or file false claims with us. Your coverage will be cancelled after you receive a written notice from us.

The ins and outs of coverage

Special enrollment periods

Typically you are only allowed to enroll in your employer's health plan during certain eligibility periods, such as when it is first offered to you as a "new hire" or during your employer's open enrollment period when employees can make changes to their benefits for an upcoming year. But there may be instances other than these situations in which you may be eligible to enroll. For example, if the first time you are offered coverage and you state in writing that you don't want to enroll yourself, your spouse or your covered dependents because you have coverage through another carrier or group health plan, you may be able to enroll your family later if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage. But, you must ask to be enrolled within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Finally, if you or your dependents' coverage under Medicaid or the state Children's Health Insurance Program (SCHIP) is terminated as a result of a loss of eligibility, or if you or your dependents become eligible for premium assistance under a state Medicaid or SCHIP plan, a special enrollment period of 60 days will be allowed. To request special enrollment or obtain more information, contact your employer.

When you're covered by multiple plans

If you're fortunate enough to be covered by more than one health plan, you may not be so thrilled about the paperwork hassles that can come with it when you're trying to figure out which plan should pay for what. Our Coordination of Benefits (COB) program helps ensure that you receive the benefits due and avoid overpayment by either carrier. Because up-to-date, accurate information is the key to our Coordination of Benefits program, you can expect to receive a COB questionnaire on an annual basis. Timely response to these questionnaires will help avoid delays in claims payment.

If you are covered by two different group health plans, one is considered primary and the other is considered secondary. The primary carrier is the first to pay a claim and provide reimbursement according to plan allowances; the secondary carrier then provides reimbursement, typically covering the remaining allowable expenses.

The ins and outs of coverage (continued)

Determining the primary versus secondary carrier

See the chart below for how determination gets made over which health plan is the primary carrier. The term “participant” is used and means the person who is signing up for coverage:

When a person is covered by 2 group plans, and	Then	Primary	Secondary
One plan does not have a COB provision	The plan without COB is	●	
	The plan with COB is		●
The person is the participant under one plan and a dependent under the other	The plan covering the person as the participant is	●	
	The plan covering the person as a dependent is		●
The person is the participant in two active group plans	The plan that has been in effect longer is	●	
	The plan that has been in effect the shorter amount of time is		●
The person is an active employee on one plan and enrolled as a COBRA participant for another plan	The plan in which the participant is an active employee is	●	
	The COBRA plan is		●
The person is covered as a dependent child under both plans	The plan of the parent whose birthday occurs earlier in the calendar year (known as the birthday rule) is	●	
	The plan of the parent whose birthday is later in the calendar year is		●
	Note: When the parents have the same birthday, the plan that has been in effect longer is	●	
The person is covered as a dependent child and coverage is stipulated in a court decree	The plan of the parent primarily responsible for health coverage under the court decree is	●	
	The plan of the other parent is		●
The person is covered as a dependent child and coverage is not stipulated in a court decree	The custodial parent's plan is	●	
	The non-custodial parent's plan is		●
The person is covered as a dependent child and the parents share joint custody	The plan of the parent whose birthday occurs earlier in the calendar year is	●	
	The plan of the parent whose birthday is later in the calendar year is		●
	Note: When the parents have the same birthday, the plan that has been in effect longer is	●	

The ins and outs of coverage (continued)

How benefits apply when Medicare-eligible

Some people under age 65 are eligible for Medicare in addition to any other coverage they may have. The following chart shows how payment is coordinated under various scenarios:

When a person is covered by Medicare and a group plan, and	Then	Anthem HealthKeepers	Medicare is Primary
Is a person who is qualified for Medicare coverage due solely to End Stage Renal Disease (ESRD-kidney failure)	During the 30-month Medicare entitlement period	•	
	Upon completion of the 30-month Medicare entitlement period		•
Is a disabled member who is allowed to maintain group enrollment as an active employee	If the group plan has more than 100 participants	•	
	If the group plan has fewer than 100 participants		•
Is the disabled spouse or dependent child of an active full-time employee	If the group plan has more than 100 participants	•	
	If the group plan has fewer than 100 participants		•
Is a person who becomes qualified for Medicare coverage due to ESRD after already being enrolled in Medicare due to disability	If Medicare had been secondary to the group plan before ESRD entitlement	•	
	If Medicare had been primary to the group plan before ESRD entitlement		•

Recovery of overpayments

If health care benefits are inadvertently overpaid, reimbursement for the overpayment will be requested. Your help in the recovery process would be appreciated. We reserve the right to recover any overpayment from:

- any person to or for whom the overpayments were made;
- any health care company; and
- any other organization.

The ins and outs of coverage (continued)

What's not covered (exclusions)

When it comes to your health, you're the final decision maker about what services you need to get and where you should get them from. But, in order for us to keep the cost of health care as low as possible for both you and your employer, we have to exclude certain services. The following list of services and supplies are excluded from coverage by your health plan and will not be covered in any case.

acupuncture

services not **authorized in advance** by us and pre-arranged by your primary care physician unless otherwise specific in this book

biofeedback therapy

over-the-counter **convenience** and hygienic items including, but not limited to, adhesive removers, cleansers, underpads, and ice bags

cosmetic surgery or procedures, including complications that result from such surgeries and/or procedures. Cosmetic surgeries and procedures are performed mainly to improve or alter a person's appearance including body piercing and tattooing. However, a cosmetic surgery or procedure does not include a surgery or procedure to correct deformity caused by disease, trauma, or a previous therapeutic process. Cosmetic surgeries and/or procedures also do not include surgeries or procedures to correct congenital abnormalities that cause functional impairment. We will not consider the patient's mental state in deciding if the surgery is cosmetic.

dental services except: medically necessary dental services resulting from an accidental injury, provided that, for an injury occurring on or after your effective date of coverage, you seek treatment within 60 days after the injury. You must submit a plan of treatment from your dentist or oral surgeon for prior approval by the HMO.

- cost of dental services and dental appliances only when required to diagnose or treat an accidental injury to the teeth
- repair of dental appliances damaged as a result of an accidental injury to the jaw, mouth or face
- dental services and appliances furnished to a newborn when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia
- dental services to prepare the mouth for radiation therapy to treat head and neck cancer
- covered general anesthesia and hospitalization services for children under the age of 5, covered persons who are severely disabled, and covered persons who have a medical condition that requires admission to a hospital or outpatient surgery facility. These services are provided when it is determined by a licensed dentist, in consultation with the covered persons' treating physician that such services are required to effectively and safely provide dental care.

The ins and outs of coverage (continued)

donor searches for organ and tissue transplants, including compatibility testing of potential donors who are not immediate, blood-related family members (parent, child, sibling)

experimental/investigative procedures, as well as services related to or complications from such procedures except for clinical trial costs for cancer as described by the National Cancer Institute. This will not prevent a member from being able to appeal Anthem's decision that a service is not experimental/investigative.

family planning

- artificial insemination services, in vitro fertilization or any other types of artificial or surgical means of conception, including drugs administered in connection with these procedures
- drugs used to treat infertility
- non-prescription contraceptive devices
- any services or supplies provided to a person not covered that is in connection with a surrogate pregnancy, including but not limited to, the bearing of a child by another woman for an infertile couple
- services to reverse voluntarily induced sterility

services for palliative or cosmetic **foot** care

- flat foot conditions
- support devices, arch supports, foot inserts, orthopedic and corrective shoes that are not part of a leg brace and fittings, castings and other services related to devices of the feet
- foot orthotics
- subluxations of the foot
- corns, calluses and care of toenails (except in treatment for patients with diabetes or vascular disease)
- bunions (except capsular or bone surgery)
- fallen arches, weak feet, chronic foot strain
- symptomatic complaints of the feet

Experimental ... or not?

Many of the Anthem HealthKeepers medical directors and staff actively participate in a number of national health care committees that review and recommend new experimental or investigative treatments for coverage. To be approved for coverage, the service or product must have:

- regulatory approval from the Food and Drug Administration;
- been put through extensive research study to find all the benefits and possible harms of the technology;
- benefits that are far better than any potential risks;
- at least the same or better effectiveness as any similar service or procedure already available; and
- been tested enough so that we can be certain it will result in positive results when used in real cases.

The ins and outs of coverage (continued)

services for surgical treatments of **gynecomastia** for cosmetic purposes

health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.

hearing care except in relation to preventive care screenings (Implantable or removable hearing aids, except for cochlear implants, are not covered.)

home care services

- homemaker services (except as rendered as part of Hospice care)
- maintenance therapy
- food and home delivered meals
- custodial care and services

hospital services

- guest meals, telephones, televisions, and any other convenience items received as part of your inpatient stay
- care by interns, residents, house physicians, or other facility employees that are billed separately from the facility
- a private room unless it is medically necessary

immunizations required for travel or work, unless such services are received as part of the covered preventive care services

medical equipment, appliances and devices, and medical supplies that have both a nontherapeutic and therapeutic use:

- exercise equipment
- air conditioners, dehumidifiers, humidifiers, and purifiers
- hypoallergenic bed linens
- whirlpool baths
- handrails, ramps, elevators, and stair glides
- telephones
- adjustments made to a vehicle
- foot orthotics
- changes made to a home or place of business
- repair or replacement of equipment you lose or damage through neglect

medical equipment (durable) that is not appropriate for use in the home

The ins and outs of coverage (continued)

services or supplies deemed not **medically necessary** as determined by the HMO at its sole discretion. Notwithstanding this exclusion, all wellness services and hospice care services described in the benefits summary that is included in this booklet are covered. This exclusion shall not apply to services you receive on any day of inpatient care that is determined by Anthem HealthKeepers to be not medically necessary if such services are received from a professional provider who does not control whether you are treated on an inpatient basis or as an outpatient, such as a pathologist, radiologist, anesthesiologist or consulting physician. Additionally this exclusion shall not apply to inpatient services rendered by your admitting or attending physician other than inpatient evaluation and management services provided to you notwithstanding this exclusion. Inpatient evaluation and management services include routine visits by your admitting or attending physician for purposes of reviewing patient status, test results, and patient medical records. Inpatient evaluation and management visits do not include surgical, diagnostic, or therapeutic services provided by your admitting or attending physician. Also, this exclusion shall not apply to the services rendered by pathologists, radiologists, or anesthesiologists in an (i) outpatient hospital setting (ii) emergency room or (iii) ambulatory surgery setting. However, this exception does not apply if and when any such pathologist, radiologist or anesthesiologist assumes the role of attending physician. This will not prevent a member from being able to appeal the HMO's decision that a service is not medically necessary.

mental health and substance abuse

- inpatient stays for environmental changes
- cognitive rehabilitation therapy
- educational therapy
- vocational and recreational activities
- coma stimulation therapy
- services for sexual deviation and dysfunction
- treatment of social maladjustment without signs of a psychiatric disorder
- remedial or special education services
- inpatient mental health treatments that meet the following criteria:
 - more than 2 hours of psychotherapy during a 24-hour period in addition to the psychotherapy being provided pursuant to the inpatient treatment program of the hospital
 - group psychotherapy when there are more than 8 patients with a single therapist
 - group psychotherapy when there are more than 12 patients with two therapists
 - more than 12 convulsive therapy treatments during a single admission
 - psychotherapy provided on the same day of convulsive therapy

services from **non-HMO** providers, except for emergencies when authorized in advance by the HMO Medical Director (this exclusion does not pertain to Point of Service plans or for an annual routine eye exam from an out-of-network provider)

These services are not covered by your Anthem HealthKeepers plan.

The ins and outs of coverage (continued)

nutrition counseling and related services, except when provided as part of diabetes education or when received as part of a covered wellness services visit or screening

nutritional and/or dietary supplements, except as specifically listed in this enrollment brochure or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

obesity services and supplies related to weight loss or dietary control, including complications that directly result from such surgeries and/or procedures. This includes weight reduction therapies/activities, even if there is a related medical problem. Notwithstanding provisions of other exclusions involving cosmetic surgery to the contrary, services rendered to improve appearance (such as abdominoplasties, panniculectomies, and lipectomies), are not covered services even though the services may be required to correct deformity after a previous therapeutic process involving gastric bypass surgery.

organ or tissue transplants, including complications caused by them, except when they are considered medically necessary, have received pre-authorization, and are not considered experimental/investigative. Autologous bone marrow transplants for breast cancer are covered only when the procedure is performed in accordance with protocols approved by the institutional review board of any United States medical teaching college. These include, but are not limited to, National Cancer Institute protocols that have been favorably reviewed and used by hematologists or oncologists who are experienced in high dose chemotherapy and autologous bone marrow transplants or stem cell transplants. This procedure is covered despite the exclusion in the plan of experimental/investigative services.

paternity testing

prescription drug benefits

- over-the-counter drugs
- any per unit, per month quantity over the plan's limit
- drugs used mainly for cosmetic purposes
- drugs that are experimental, investigational, or not approved by the FDA
- cost of medicine that exceeds the allowable charge for that prescription
- drugs for weight loss
- stop smoking aids
- therapeutic devices or appliances
- injectable prescription drugs that are supplied by a provider other than a pharmacy
- charges to inject or administer drugs
- drugs not dispensed by a licensed pharmacy
- drugs not prescribed by a licensed provider
- infertility medication
- any refill dispensed after one year from the date of the original prescription order
- medicine covered by workers' compensation, Occupational Disease Law, state or government agencies
- medicine furnished by any other drug or medical service

The ins and outs of coverage (continued)

rest cures, custodial, residential or domiciliary care and services. Whether care is considered residential will be determined based on factors such as whether you receive active 24-hour skilled professional nursing care, daily physician visits, daily assessments, and structured therapeutic service.

services or supplies or devices

- ordered by a doctor whose services are not covered under your health plan
- not listed as covered under your health plan
- not prescribed, performed, or directed by a provider licensed to do so
- received before the effective date or after a covered person's coverage ends
- for injuries or illnesses incurred as a result of your commission of, or attempt to commit, a crime
- services prescribed, ordered, referred by or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self
- benefits for charges from stand-by physicians in the absence of covered services being rendered
- telephone consultations, charges for not keeping appointments, or charges for completing claim forms

services or supplies if provided or available to a member:

- under the Medicare program or under any similar program authorized by state or local laws or regulations or any future amendments to them. This exclusion does not apply to those laws or regulations which make the government program the secondary payor after benefits under this plan have been paid.
- provided under a U.S. government program or a program for which the federal or state government pays all or part of the cost. This exclusion does not apply to health benefits plans for civilian employees or retired civilian employees of the federal or state government.

services for which a charge is not usually made including those services for which you would not have been charged if you did not have health care coverage services or benefits for:

- amounts above the allowable charge for a service
- for which a charge is not usually made, including those not typically charged to members without coverage
- self-administered services or self care including self-administered injections
- self-help training
- neurofeedback, and related diagnostic tests

services or supplies primarily for educational, vocational, or self-management/training purposes, except as otherwise specified, except when received as part of a covered wellness services visit or screening

The ins and outs of coverage (continued)

sexual dysfunction surgery or sex transformation services, including medical and mental health services

services of non-HMO providers except for emergencies or when authorized in writing by our Medical Director including services not pre-arranged by your primary care physician and authorized in advance by us:

- women in at least their second trimester of pregnancy can continue to see their doctors who have left the Anthem HealthKeepers network, unless the doctors were asked to leave for cause
- members with a terminal illness who are expected to live less than six months can continue to see their doctors who have left the Anthem HealthKeepers network, unless the doctors were asked to leave for cause (this exclusion does not apply to Point of Service plans)

skilled nursing facility stays

- treatment of psychiatric conditions and senile deterioration
- facility services during a temporary leave of absence from the facility
- a private room unless it is medically necessary

smoking cessation programs not affiliated with us

spinal manipulation and manual medical therapy services (chiropractic care)

- any treatment or service not authorized by American Specialty Health Network, Inc. (ASHN)
- any service or treatment not provided by an ASHN provider (this exclusion does not apply to Point of Service plans) services for examination and/or treatment of strictly nonneuromusculoskeletal disorders, or conjunctive therapy not associated with spinal or joint adjustment
- laboratory tests, x-rays, adjustments, physical therapy or other services not documented as medically necessary and appropriate or classified as experimental/investigative or in the research stage
- diagnostic scanning, including Magnetic Resonance Imaging (MRI), CAT scans and/or other types of diagnostic scanning, thermography
- educational programs, non-medical self-care and or self-help, or any self-help physical exercise training or
- any related diagnostic training
- air conditioners, air purifiers, therapeutic mattresses, supplied or any similar devices or appliances
- vitamins, mineral, nutritional supplements or any other similar type product

telemedicine

- non-interactive telemedicine services, including audio only telephone, electronic mail message or facsimile transmission

The ins and outs of coverage (continued)

therapies

- physical therapy, occupational therapy, or speech therapy to maintain or preserve current functions if there is no chance of improvement or reversal except for children under age 3 who qualify for early intervention services
- group speech therapy
- group or individual exercise classes or personal training sessions
- recreation therapy including, but not limited to, sleep, dance, arts, crafts, aquatic, gambling, and nature therapy

services for treatment of varicose veins or telangiectatic dermal **veins** (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes

vision services

- vision services or supplies unless needed due to eye surgery and accidental injury
- routine vision care and materials
- services for radial keratotomy and other surgical procedures to correct refractive defects such as nearsightedness, farsightedness and/or astigmatism. This type of surgery includes keratoplasty and Lasik procedure;
- services for vision training and orthoptics
- tests associated with the fitting of contact lenses unless the contact lenses are needed due to eye surgery or to treat accidental injury
- sunglasses or safety glasses and accompanying frames of any type
- any non-prescription lenses, eyeglasses or contacts, or Plano lenses or lenses that have no refractive power
- any lost or broken lenses or frames
- any blended lenses (no line), oversize lenses, progressive multifocallenses, photchromatic lenses, tinted lenses, coated lenses, cosmetic lenses or processes, or UV-protected lenses
- services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the employer or any government entity
- any other vision services not specifically listed as covered

weight loss programs whether or not they are pursued under medical or physician supervision, unless specifically listed as covered. This exclusion includes, but is not limited to commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

services or supplies if they are for **work-related** injuries or diseases when the employer must provide benefits by federal, state, or local law or when that person has been paid by the employer. This exclusion applies even if you waive your right to payment under these laws and regulations or fail to comply with your employer's procedures to receive the benefits. It also applies whether or not the covered person reaches a settlement with his or her employer or the employer's insurer or self insurance association because of the injury or disease.

Health, Wellness & Anthem Advantages

Get the most out of your health plan

anthem.com

Clear. Intuitive. Easy.

Save money and live better with tools that keep you informed, in control, and at your healthy best.

Health and wellness

Now it's easier than ever to improve your health and well-being. Simply log in at anthem.com. You have access to an array of innovative tools to help you manage your health and achieve your goals.

MyHealth Assessment

Your first step toward a healthier lifestyle

Gain personal insights into your current health, your health risks, and what you can do to enjoy a healthier life. You complete a confidential assessment of your health and health care status, then receive a health assessment score and risk profile based on your specific answers. You also get tips and actions to help you improve your health.

To use MyHealth Assessment:

- Visit anthem.com
- Click on "Health & Wellness"
- Under Health Assessment, select "Take my HA now"

MyHealth Record

Your health history in one secure location

Keep your medical records organized, secure and easily accessible for emergencies and everyday use. Enter your information such as dates of immunizations, tests and screenings, prescription and over-the-counter drugs you take, medical conditions and more. Print and share with your doctors to help avoid potential drug interactions and duplicative tests and procedures.

To use MyHealth Record:

- Visit anthem.com
- Click on "Health & Wellness"
- Under Health Assessment, select "Start your Health Record"

SpecialOffers

Discounts on health-related products and services

Get the most out of your health plan

Enjoy members-only discounts on vitamins, health and beauty products, chiropractic care, acupuncture, massage therapy, LASIK eye surgery, eyeglass frames and contact lenses, hearing aids, and audiology services, fitness center memberships, weight-loss programs and more.

To access all discounts:

- Log in at anthem.com
- Click on “Health & Wellness”
- On far right side of page, see “Discounts”
- Click on “Access your Discount”

Zagat® Health Survey

Doctor recommendations from your peers

Benefit from the experiences of fellow Anthem HealthKeepers members to help you find the doctor that's right for you. We've teamed with Zagat Survey, the world's most trusted source of recommendations by consumers, for consumers, to let you rate your doctors and see what others say about them.

To access the Zagat Health Survey:

- Log in at anthem.com
- Go to your Account Summary page to rate your Recently Visited Providers
- Under Customize your Summary, click/drag/drop “Recently Visited Doctors”
- See Zagat logo and link to “Rate this doctor”

Healthy Lifestyles

Support to help you achieve your goals

Lose weight, stop smoking, stress less and exercise more with our online tools and resources. Take advantage of online fitness tracking and customized workout plans, discounts on spa services and massage therapists, healthy recipes, smoking cessation programs and more. Plus, get the support you need at our online community forums.

To learn more:

- Log in at anthem.com
- Click on “Health & Wellness”
- Under “Healthy Lifestyles” select “Get Started”

Plans and benefits

Anthem.com makes complex information easy to understand and easy to use. That makes it easier to make the right decisions for you and your family.

Get the most out of your health plan

Anthem Care Comparison

Quality and cost information at your fingertips

Make informed decisions and save money by comparing actual costs for common procedures at hospitals and facilities in your area. In addition to price information, you can see procedure and quality comparisons that gauge performance and safety at each facility.

To use Anthem Care Comparison:

- Log in at anthem.com
- Go to your Account Summary page and select “Compare Facility Cost and Quality”
- Click/drag/drop “Compare Cost & Quality”
- Select “Compare Facility Cost & Quality”

Coverage AdvisorSM

A customized comparison of your health care needs and costs

You have a wide range of Anthem HealthKeepers health plans to choose from; Coverage Advisor helps you choose the right one for you and your family. It helps you forecast your health care needs and costs and provides you with a clear comparison of benefit plans. If you have a medical savings account, it can also recommend contribution amounts to help cover expenses.

To use Coverage Advisor:

- Log in at anthem.com
- Go to Resources under “Plans & Benefits”
- Select the Blue “Plans & Benefits” panel
- On the far right side, select “Access Coverage Advisors”

Claims look-up

Easy access to claims information

Stay on top of your medical claims with this easy online view. You can see the amounts charged to your medical savings account, the amounts paid by your traditional health coverage, or the amounts for which you’re responsible. You may also choose to receive an email when a claim has been processed, instead of receiving notification by mail.

To look up a claim:

- Log in at anthem.com
- Click on “Plans & Benefits”
- On right side Welcome area, select “Check Claim Status”

Online Provider Finder

The quick and easy way to find your doctor

Get the most out of your health plan

Search for doctors, hospitals and other health care facilities quickly online. You can make your search more specific by choosing a specialty or entering the name of a doctor or facility. If you're away from home, you can also search our National Directory.

To search our online Provider Finder:

- Visit [anthem.com](https://www.anthem.com)
- Select "Find a Doctor" and simply follow the steps outlined on the screen

Temporary ID card

Use it until you get your permanent ID card

We know the peace of mind your member identification (ID) card brings you and your loved ones. That's why we've made sure you can have it wherever you go.

If you haven't received your permanent ID card yet and want to access health care services, you can print your temporary ID card online by logging on to **[anthem.com](https://www.anthem.com)**.^{*} Your temporary ID card letter **expires 30 days after its issue date** and isn't meant to replace your permanent ID card, which you'll still receive.

^{*}Not all members may be able to request a temporary ID card.

Not registered at [anthem.com](https://www.anthem.com)?

Sign up now for access to personalized service and resources. It's fast, easy and secure.

360° Health® programs

The programs you read about here come with your health plan. There is no extra cost for them.

To learn more about these programs online, log in to anthem.com and click on MyHealth@Anthem.

Take charge of your health and the choices you make

We all have different health needs. Maybe you're fit and want to stay that way. Maybe you're living with a chronic condition like asthma. Or maybe you fall somewhere in between. No matter where you fall, our 360° Health program is here to give you all the help you need to live healthier. From tips and tools you can find online to nurses you can talk to on the phone, 360° Health can help you take better control over your health. And it can give you the power to make the decisions that are right for you.

24/7 NurseLine

Round-the-clock access to health information can really help your peace of mind and your physical well-being. That's why we have Nurse Coaches ready to speak with you about your general health issues any time of the day or night. Just call the 24/7 NurseLine toll-free number to get answers to questions like these:

- Can the problem be treated at home?
- Do you need to see your doctor?
- Should you head straight to the emergency room?

Making the right call can help you avoid unnecessary worry and costs. And, most importantly, safeguard your health and the health of your family.

To reach 24/7 NurseLine, just call the customer service number on your ID card and ask to speak to a 24/7 NurseLine representative.

Future Moms

We know your goal is to have a safe delivery and a healthy baby. That's why we offer Future Moms, a voluntary program to help you take care of your baby before you deliver. Register for Future Moms and you'll get:

- 24/7 toll-free access to a registered nurse who'll answer your questions and talk to you about pregnancy-related issues.
- A helpful book: *Your Pregnancy Week by Week*
- Tips and facts to help you handle any unexpected events
- A questionnaire to see if you're at risk for preterm delivery

360° Health® programs

- Useful tools to help you, your doctor and your Future Moms nurse track your pregnancy and spot possible risks

Enroll in Future Moms by calling the customer service number on your ID card. Ask to speak to a Future Moms representative.

ConditionCare

If you or someone you love has an ongoing illness or health problem, let us help you get more out of life. Our ConditionCare nurses help people of all ages take care of the symptoms of asthma and diabetes. And they work closely with adults who have chronic obstructive pulmonary disease (COPD), heart failure and coronary artery disease. With ConditionCare you'll get the information you need to help you feel your very best. Our ConditionCare nurses gather information from you and your doctor. Then they create a personalized plan for you.

Information and support are as close as your phone. Call the customer service number on your ID card and ask to speak to a ConditionCare Nurse.

MyHealth Advantage

MyHealth Advantage can keep you and your bank account healthier.

Here's how it works: We review your health status daily and check to see what medications you're taking. If we see that any of your medicines could interact with each other, we tell your doctor right away. We also keep track of when you need to get routine tests and checkups. We send you a reminder called a "MyHealth Note" when you should make these appointments. MyHealth Note has a summary of all your recent claims. And from time to time, we give you tips on how to save you money on your medications.

ComplexCare

ComplexCare is for our members with more than one health problem or a condition that puts them at risk for needing more care, more often. If you sign up for ComplexCare, you, your family and your doctors will work with a ComplexCare nurse and others on our staff. They'll help you meet health goals and help you avoid going in and out of the hospital.

With ComplexCare, you have 24/7 toll-free access to nurses who will work one-on-one with you to teach you about taking care of your condition while living the life you like to live. They'll also help you learn about why it's important to go for regular checkups and screenings. The nurses can help you make better choices about your care. They can also help make sure your doctors are all talking to each other about your care and what's best for you. If you qualify for the ComplexCare program, a nurse will contact you.

To learn more, log on to anthem.com or contact the customer service number on your ID card.

360° Health® programs

Healthy Lifestyles

Healthy Lifestyles is a free online program that gives you support and rewards to help you stay healthy or get healthier. Whether you want to quit smoking, lose weight, eat right, exercise more or manage stress, Healthy Lifestyles makes it easy to set goals, track your progress and earn rewards. With Healthy Lifestyles, you can:

- Sign up for a program to quit smoking
- Use nutrition and fitness trackers
- Find healthy recipes
- Join community and online forums
- Get discounts on massages, gym memberships, spa services and more

A healthier lifestyle can be just a mouse click away. To learn more, visit [anthem.com](https://www.anthem.com).

Employee Assistance Program

When life isn't going your way, it can take a toll on your physical and mental health. Your Employee Assistance Program (EAP) can help. The program will help you find the support you need to get back on track. When you call, you'll work with a representative who will help you figure out your next steps. For example, setting up free visits with a licensed counselor or putting you in touch with a financial advisor or lawyer if you're having money or legal issues. If you need even more help, we'll set up something with someone near you.

Since you never know when life will throw you a curve ball, your EAP is available 24/7 to you and everyone who lives with you.

Just call the customer service number on your ID card and ask to speak to an EAP representative.

Information You Should Know

Managing your care if you need to go to a hospital or get a specific medical treatment

If you or a family member needs a certain type of medical care (for example: surgery, a treatment done in a doctor's office, physical therapy, etc.), you may want to know more about the following programs and definitions. They may help you better understand how your benefits work and how your health plan manages your care in these types of situations.

Utilization Management

Utilization Management (UM) is a program that is part of your health plan that lets us make sure you're getting the right care at the right time. Our UM program is made up of a team of licensed health care professionals such as nurses and doctors who do medical reviews. The UM review team goes over the information we have received from your doctor or other health care provider to see if a surgery, treatment or other type of care that has been requested is medically needed. The UM review team checks to make sure that the treatment meets specific rules set by your health plan. After reviewing the records and information, the surgery or treatment will be approved (covered) or denied (not covered) and the UM review team will let you and your doctor know as soon as possible.

Medical reviews like this can be done before, during and after a member's treatment. Here's an explanation of each type of review:

The prospective or pre-service review (done before medical care is given)

A prospective review is done before a member goes to the hospital or has some other type of service or treatment.

Here are some types of medical needs members may have that might call for a prospective review:

- To go to (and/or stay at) a hospital
- An outpatient procedure (the member can go home the same day)
- Tests done to try to find the cause of an illness such as MRI (Magnetic Resonance Imaging) and CT (Computed Tomography) scans
- A certain type of outpatient therapy such as physical therapy or emotional health counseling
- "Durable medical equipment" (DME) which means wheelchairs, walkers, crutches, hospital beds and more

The concurrent review (done during medical care and recovery)

A concurrent review is done at the time the member is in the hospital or is released and needs more care related to the hospital stay. This could mean services or treatment done in a doctor's office, regular office visits, physical or emotional therapy, home health care, durable medical equipment (see above), staying in a nursing home, getting emotional health care and more. The UM review team looks at the member's medical information at the time of the review to see if the treatment is medically needed.

Managing your care if you need to go to a hospital or get a specific medical treatment

The retrospective or post-service review (done after medical care is given)

A retrospective review is done when a member has already had surgery or another type of medical care. When the UM review team becomes aware of the treatment, they will look at the member's medical information that the doctor or provider had at the time the medical care was given. They can then see if the treatment was medically needed.

Case Management

Case managers are licensed health care professionals who work with you and your doctor to help you learn about and manage your health conditions, and help you better understand your health benefits.

Your rights and responsibilities as an Anthem HealthKeepers member

As an Anthem HealthKeepers member you have certain rights and responsibilities to help make sure that you get the most from your plan and access to the best care possible. That includes certain things about your care, how your personal information is shared and how you work with us and your doctors. It's kind of like a "Bill of Rights". And helps you know what you can expect from your overall health care experience and become a smarter health care consumer.

You have the right to:

- Speak freely and privately with your doctors and other health professionals about all health care options and treatment needed for your condition, no matter what the cost or whether it's covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect, dignity, and the right to privacy.
- Privacy, when it comes to your personal health information, as long as it follows state and federal laws, and our privacy rules.
- Get information about our company and services, and our network of doctors and other health care providers.
- Get more information about your rights and responsibilities and give us your thoughts and ideas about them.
- Give us your thoughts and ideas about any of the rules of your health care plan and in the way your plan works.
- Make a complaint or file an appeal about:
 - Your health care plan
 - Any care you get
 - Any covered service or benefit ruling that your health care plan makes
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future; and the right to have your doctor tell you how that may affect your health now and in the future
- Participate in matters that deal with the company policies and operations.
- Get all of the most up-to-date information about the cause of your illness, your treatment and what may result from that illness or treatment from a doctor or other health care professional. When it seems that you will not be able to understand certain information, that information will be given to someone else that you choose.
- Get help at any time, by contacting your local insurance department.

You have the responsibility to:

- Choose any primary care physician (doctor), also called a PCP, who is in our network if your health care plan says that you to have a PCP.
- Treat all doctors, health care professionals and staff with courtesy and respect.

Your rights and responsibilities as an Anthem HealthKeepers member (continued)

- Keep all scheduled appointments with your health care providers and call their office if you have a delay or need to cancel.
- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- To the extent possible, understand your health problems and work with your doctors or other health care professionals to make a treatment plan that you all agree on.
- Follow the care plan that you have agreed on with your doctors or health care professionals.
- Tell your doctors or other health care professionals if you don't understand any care you're getting or what they want you to do as part of your care plan.
- Follow all health care plan rules and policies.
- Let our Customer Service department know if you have any changes to your name, address or family members covered under your plan.
- Give us, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health care plans and insurance benefits you have in addition to your coverage with us.

For details about your coverage and benefits, please read your "Subscriber Agreement".

Important legal information you should take time to read

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act explains your rights for treatment under the health plans if you need a mastectomy. Plain and simple... we're here for you.

If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your Anthem Blue Cross and Blue Shield benefits comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.
- All applicable benefit provisions will apply, including existing deductibles, copayments and/or co-insurance.

HIPAA NOTICE OF PRIVACY PRACTICES

The HIPAA Notice of Privacy Practices explains the rules around how we handle your private information under HIPAA laws. Plain and simple... we don't share your information unless it's needed to manage your benefits or you give us the OK to do it.

We keep the health and financial information of our current and former members private as required by law, accreditation standards, and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use, and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For Payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.

For Health Care Operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes, or traumatic injury.

For Treatment Activities: We do not provide treatment. This is the role of a health care provider such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To You: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your

Important legal information you should take time to read (continued)

dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To Others: You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present, and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As Allowed or Required by Law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors or medical examiners (about decedents). PHI can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for workers' compensation, to respond to requests from the U.S. Department of Health and Human Services and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law.

If you are enrolled with us through an employer sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Genetic Information: If we use or disclose PHI for underwriting purposes, we are prohibited from using or disclosing PHI that is genetic information of an individual for such purposes.

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask them to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI.

Important legal information you should take time to read (continued)

Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. They can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How we protect information

We are dedicated to protecting your PHI. We set up a number of policies and practices to help make sure your PHI is kept secure.

We keep your oral, written, and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include offices that are kept secure, computers that need passwords, and locked storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. The policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people, who do not belong, out of areas where sensitive data is kept. Also, where required by law, our affiliates and non-affiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Potential Impact of Other Applicable Laws

HIPAA (the federal privacy law) generally does not preempt, or override other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact Information

Please call Customer Service at the phone number printed on your ID card. They can help you apply your rights, file a complaint, or talk with you about privacy issues.

Copies and Changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Important legal information you should take time to read

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This Notice is provided by the following company: **Anthem Blue Cross and Blue Shield**

STATE NOTICE OF PRIVACY PRACTICES

As we told you in our HIPAA notice, we must follow state laws that are more strict than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law.

Your Personal Information

We may collect, use and share your nonpublic personal information (PI) as described in this notice.

We may collect PI about you from other persons or entities such as doctors, hospitals, or other carriers.

We may share PI with persons or entities outside of our company without your OK in some cases.

If we take part in an activity that would require us to give you a chance to opt-out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI.

Because PI is defined as any information that can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you.

A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

Health care reform and your plan

You've most likely heard a lot of people talk about health care reform lately. But you may have questions about what it all means for you and your family. Here's a quick review of what the new law may mean to your group health plan. Keep in mind that other company plans may have different rules. If you have questions about your specific benefits, call the customer service number on your member ID card or ask your group benefits administrator for a number to call.

What's changed: When you join, you'll have a chance to add young adult children to your plan.

The federal health care reform law lets children (also called dependents) stay on their parent's or guardian's health plan until the end of the month when they turn 26 years old. In some states, they can stay on the plan even longer.

Children can be on your plan even if they are not:

- Financially dependent on you for support
- Claimed as dependents on your tax return
- Residents of your household
- Enrolled as students or unmarried

If you have children younger than 26 who aren't on your plan now and your company offers coverage for children, you can add them to your plan during your next open enrollment. If your plan already covers children up to age 26, you don't have to do anything. They'll stay on your plan automatically.

What's changed: Children under 19 can get coverage even if they have health problems.

The law says group health plans can't deny coverage to children under 19 if they have pre-existing conditions (health problems). Here's how a website run by the federal government, called healthcare.gov, defines a pre-existing condition: a pre-existing condition is "a condition, disability or illness (either physical or mental) that you have before you enrolled in a health plan."

Very few group health plans deny coverage because of pre-existing conditions. But some plans still have waiting periods. A waiting period means that a child under 19 has to wait a certain amount of time before he or she can get covered for certain services.

Health care reform and your plan (continued)

What's changed: No more lifetime maximum dollar limits.

In the past, health plans could have a “lifetime maximum” – a dollar limit on what the plan will pay for health care services over your lifetime. If your plan had a lifetime maximum, it's gone now. But other limits may still apply. For example, you may have limits on certain services that aren't considered “essential health benefits.” Also, you may have limits on how many times you can use a benefit during the year. Check your Summary of Benefits to see if this applies to you.

What's new: You may have more choices in which doctors you can use.

This part of the law applies to you only if your plan says that you must choose a primary care provider (PCP) and get referrals from your PCP to see a specialist.

- If you have this type of plan (like an HMO), you can choose any PCP as your primary care doctor but the doctor has to be in our network, has to be accepting new patients and will accept you or your family members as patients.
- If your plan covers children, you may choose a pediatrician as their PCP.
- Also, you don't need a referral from your PCP or prior approval from your health care plan to see a gynecologist or obstetrician, as long as those doctors are in our network.

What's next? We'll keep you in the loop.

Things are going to keep on changing for a while. This notice only includes changes that may affect you within the next year. As things continue to change, we'll keep you up to date to make sure you get all the benefits that can help you and your family get and stay as healthy as possible.



EXPRESS SCRIPTS®

HOME DELIVERY PHARMACY ORDER FORM

To MAIL your prescription:

1. "Patient" box must be filled out.
2. Have your Doctor write a prescription.
3. Send your new prescription along with this completed form to:
Express Scripts Home Delivery Service
PO Box 66785
St. Louis MO 63166-6785

To FAX your prescription:

1. Both "Dr/Prescriber" and "Rx Form" boxes must be filled out.
2. Doctor can fax to: 1-800-600-8105
 - **Class II prescriptions cannot be faxed.**
 - Faxes will only be accepted from a doctor's office.

PATIENT

Member ID: _____
First Name: _____ Last Name: _____
Date of Birth: _____ Phone: _____
Address: _____
E-mail: _____
Allergies: _____
Health Conditions: _____
Over-the-Counter Medications: _____

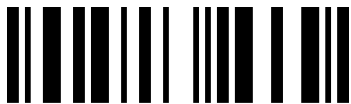
DOCTOR/PRESCRIBER

DEA: _____
Name: _____
Address: _____
Phone: _____
Fax: _____

PATIENT OPTIONS

- ☐ I want non-child resistant caps, when available.
- ☐ I want a copy of my bottle label in large print on a separate sheet of paper.
- ☐ Check here for rush delivery. Once your order is received and filled, it will be shipped overnight for \$21.

If you want to make a payment or update your health conditions, please visit your health plan provider's website.



2161

Rx

First Name

Last Name

Date: ____ / ____ / ____

Drug Name/Form/Strength

Qty

Directions for Use

Refills

X

Doctor/Prescriber Signature – Substitution Permissible

X

Doctor/Prescriber Signature – Dispense as Written

Stamped signatures cannot be accepted.

Important Confidentiality Notice: This and any documents accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.



**Don't forget to click
here to give us your
feedback if you have
not already done so.**

**Once you're a member, it's easy to get answers to
any questions about your plan.**

**Just call the number on the back of your member
identification (ID) card after you get it.**



Anthem[®] HealthKeepers
Offered by HealthKeepers, Inc.

The most detailed description of benefits, exclusions and restrictions can be found in the following publications which are issued upon initial enrollment or at renewal. If you have questions, please contact your agent, Group Administrator, or member services:

H-INTRO-HK (1/12), H-TOC (7/11), H-SB-HMO (7/11), H-SB-POS (3/12), H-SB LUM (3/12), H-WORKS-HK (3/12), H-COVERED-HK (3/12), H-EXCL (3/12), H-CLAIMS-HK (1/12), H-COB (7/10), H-ENR (10/10), H-ENDS (7/10), H-RIGHTS (7/09), H-DEF-HK (3/12), H-EXH-A (10/10), H-INDEX (7/10)

Enrollment applications used for Anthem HealthKeepers: 490760 (10/10), 490773 (10/10)

This is not a contract or policy. This brochure is not a contract with Anthem HealthKeepers offered by HealthKeepers, Inc. If there is any difference between this brochure and the Evidence of Coverage, Summaries of Benefits, and related Amendments, the provisions of the Evidence of Coverage, Summaries of Benefits and related Amendments will govern. For more information, please call Member Services at 800-421-1880. Member Services may also be contacted at PO Box 26623 Richmond, VA 23261-0031

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Express Scripts, Inc. is a separate company that provides pharmacy services and pharmacy benefit management services on behalf of health plan members.

Visit us online at anthem.com